MDR Tracking Number: M5-04-3386-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 6-4-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that therapeutic exercise, ultrasound, and physical therapy re-evaluation for dates of service 2-23-04 through 3-19-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 2-23-04 through 3-19-04 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of August 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

MEDICAL REVIEW OF TEXAS
[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3386-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

August 6, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Documents reviewed: Dr. M's physical therapy review; Dr. H office notes, s/p rotator cuff repair and operative note from 11/20/03; right shoulder arthrogram from 10/13/03.

60-year-old male s/p ___ rotator cuff tear from work related activity. s/p rotator cuff repair and SLAP repair, subacrominal decompression and distal clavicle excision.

REQUESTED SERVICE(S)
Medical necessity of 97110-therapeutic exercises, 97035-ultrasound, 97002-physical therapy re-evaluation for dates of service 2/23/04 through 3/19/04.

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION
After more than twenty therapy visits, further therapies are not appropriate, nor is ultrasound. Please see pivotal peer reviewed literature by Drs. B, D, W and AB.